STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF SUPERVISION

Applicant's Name _____ Phone _____

Mailing Address _____

Name of Supervisor _____ Title _____

Dates Employed from _____ to _____

TO BE COMPLETED BY SUPERVISOR

Name and Title: _____

Agency/Organization employed by during supervision of above applicant: _____

At the time such supervision was provided, please list the states in which you were licensed/certified as a Marital and Family Therapist:

License Number: _____ Initial date of licensure/certification: _____

Dates postgraduate supervision provided: From _____/_____/_____ To _____/_____/_____

How many hours of supervision did you provide to the candidate? _____

How many hours of supervision were with either one or two supervisees present in the room? _____

Do you have any derogatory information regarding the competency or conduct of the applicant? YES ☐ NO ☐

If yes, please explain (attach additional sheet if necessary): _____

_____

_____

Supervisor: By signing and dating below, you are attesting that the individual named above successfully completed the experience, and is able to function independently in delivering marriage and family therapy services.

Supervisor Name (Please Print) _____

Supervisor Signature: _____ Date: _____/_____/_____

This form must be returned by the supervisor directly to:

DEPARTMENT OF PUBLIC HEALTH
MARITAL AND FAMILY THERAPY LICENSURE
410 CAPITOL AVE., MS# 12APP
P.O. BOX 340308
HARTFORD, CT 06134-0308